

wisconsin Medicaid update

and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:
Specialized
Medical Vehicle
Providers
HMOs and Other
Managed Care
Programs

New trip ticket form for specialized medical vehicles

A new, optional Specialized Medical Vehicle (SMV) Trip Ticket/Medical Care Verification Form is attached to this Update. The form was developed in response to provider suggestions and will be available for use on and after October 1, 2000.

New form available

Wisconsin Medicaid has developed an optional Specialized Medical Vehicle (SMV) Trip Ticket/Medical Care Verification Form. The new form features more space for provider responses and larger print for easier reading, but providers are not required to use it.

However, if you choose to develop and use an alternate version of the new form, all elements must be included except Element 21. Still, Wisconsin Medicaid encourages providers to include Element 21.

Refer to Attachment 1 of this *Update* for instructions on how to complete the new SMV trip ticket form. Refer to Attachment 2 for two copies of the new form that can be reproduced on one sheet of paper.

Elements that have been added to the SMV trip ticket form

The following elements have been added to the new SMV trip ticket form:

- Element 8: Unloaded Mileage - Dispatch location.
- Element 9: Unloaded Mileage - Odometer Readings.
- Element 10: Pick Up Address.
- Element 12: Drop Off Address.
- Element 14: Name of Facility.
- Element 18: Multiple Riders This Trip.
- Element 19: Name of Primary Rider.
- Element 20: Wheelchair? Cot or Stretcher?
- Element 21: Signature of Person Verifying the Medicaid-Covered Service/Title/Date (optional).

Note: Providers must now use *actual* odometer readings for Elements 9, 11, and 13. No other mileage calculations, such as grid maps, city block calculations, etc., will be accepted.

Trip ticket includes medical verification

The new SMV trip ticket includes information required on the medical care verification form. When providers complete the new SMV trip ticket, including Element 21, they will no longer need to complete a separate, optional medical care verification form.

Remove the current SMV trip ticket located in the Reproducible Forms section of your SMV Handbook and replace it with the new form in Attachment 2. Questions about the new form should be directed to Provider Services at (800) 947-9627 or (608) 221-9883.

Verify eligibility of recipients

Providers should always verify the eligibility of any Wisconsin Medicaid recipient they are serving. Possession of a Medicaid ID card does not guarantee eligibility.

Providers should use the Eligibility Verification System (EVS) to verify eligibility whether or not a recipient has a Medicaid ID card. Refer to the Provider Resources section of the All-Provider Handbook for more information on using the EVS.

This *Update* applies to fee-for-service Medicaid providers only. If you are a Medicaid

HMO network provider, contact your managed care organization for more information about its billing procedures. Wisconsin Medicaid HMOs are required to provide at least the same benefits for enrollees as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at www.dhfs.state.wi.us/medicaid/.

ATTACHMENT 1

Instructions on how to complete the Specialized Medical Vehicle (SMV) Trip Ticket/Medical Care Verification Form

Use the following instructions to complete the SMV trip ticket form.

All elements listed below must be completed except Element 21, which remains optional.

Element 1: Provider Name

Enter name of transportation provider or business.

Element 2: Vehicle

Enter one of the following:

- Vehicle identification number (VIN).
- License plate number.
- Locally assigned number.
- Human service vehicle (HSV) company or fleet number.

Element 3: Date

Enter date of transportation.

Element 4: Driver Name

Enter name of driver.

Element 5: Driver Signature

Signature of driver.

Element 6: Recipient Name

Enter recipient's complete name.

Element 7: Recipient Identification Number

Enter the number taken from the Wisconsin Medicaid Forward card or a temporary Medicaid ID card that has been provided. Provider should verify that the recipient is eligible for Medicaid at the time the transportation is provided.

Element 8: Unloaded Mileage - Dispatch Location

Enter the exact physical street address, including city and state, where the vehicle is at the time it is dispatched. Be specific in terms of address and street, highway number with mile marker, etc.

Element 9: Unloaded Mileage - Odometer Readings

Enter the beginning and ending unloaded mileage readings. Providers must use actual odometer readings, including tenths of a mile. No other mileage calculations, such as grid maps, city block calculations, etc., will be accepted.

Element 10: Pick Up Address

Enter the exact physical street address, including city and state, where the recipient is picked up.

Element 11: Odometer Reading Start and Time

Enter the exact odometer reading (including tenths of a mile) at the exact location where the recipient is picked up and the time (for example, 10:25 a.m.) the recipient is picked up. Providers must use actual odometer readings. No other mileage calculations, such as grid maps, city block calculations, etc., will be accepted.

Element 12: Drop Off Address

Enter the exact physical street address, including city and state, where the recipient is dropped off.

Element 13: Odometer Reading End and Time

Enter the exact odometer reading (including tenths of a mile) at the exact location where the recipient is dropped off and the time (for example, 10:25 a.m.) the recipient is dropped off. Providers must use actual odometer readings. No other mileage calculations, such as grid maps, city block calculations, etc., will be accepted.

Element 14: Name of Facility

Enter the name of the clinic, hospital, rehabilitation center, etc., where the recipient is taken.

Element 15: Type of Facility or Reason for Trip

Enter the type of facility (e.g., clinic, dental office, physician, etc.) or reason for appointment (e.g., dental appointment).

Element 16: Waiting Time

Enter the exact waiting time (for example, from 10:25 to 11:15 a.m.) if the driver waits for the recipient.

Element 17: Second Attendant's Name

Enter the name of the person who is the second attendant if applicable.

Element 18: Multiple Riders This Trip

Circle "yes" or "no" depending on whether or not there are multiple riders.

Element 19: Name of Primary Rider

Enter the name of the primary rider if applicable.

Element 20: Wheelchair? Cot or Stretcher?

Circle the appropriate response regarding transportation provided.

Element 21: Signature of Person Verifying the Medicaid-Covered Service/Title/Date (optional)

This box must be signed and dated by the person verifying that the recipient is receiving a Medicaid-covered service at that location. This person should also list his or her working title (e.g., receptionist, nurse, doctor, etc.).

ATTACHMENT 2

Two copies of the "Specialized Medical Vehicle (SMV) Trip Ticket/
Medical Care Verification Form" are on the following page

SPECIALIZED MEDICAL VEHICLE (SMV) TRIP TICKET/MEDICAL CARE VERIFICATION FORM

1. Provider Name _____ 2. Vehicle _____ 3. Date _____

4. Driver's Name _____ 5. Driver's Signature _____

6. Recipient Name		7. Recipient Identification Number	
8. Unloaded Mileage - Dispatch Location		9. Unloaded Mileage - Odometer Readings Start _____ End _____	
10. Pick Up Address		11. Odometer Reading Start _____ Time _____ AM/PM	
12. Drop Off Address		13. Odometer Reading End _____ Time _____ AM/PM	
14. Name of Facility		15. Type of Facility or Reason for Trip	
16. Waiting Time AM/PM to _____ AM/PM		17. Second Attendant's Name	
18. Multiple Riders this Trip Yes _____ No _____		19. Name of Primary Rider	
20. Wheelchair? Yes _____ No _____		Cot or Stretcher? Yes _____ No _____	
21. Signature of Person Verifying the Medicaid-Covered Service _____		Title _____	Date _____

SPECIALIZED MEDICAL VEHICLE (SMV) TRIP TICKET/MEDICAL CARE VERIFICATION FORM

1. Provider Name _____ 2. Vehicle _____ 3. Date _____

4. Driver's Name _____ 5. Driver's Signature _____

6. Recipient Name		7. Recipient Identification Number	
8. Unloaded Mileage - Dispatch Location		9. Unloaded Mileage - Odometer Readings Start _____ End _____	
10. Pick Up Address		11. Odometer Reading Start _____ Time _____ AM/PM	
12. Drop Off Address		13. Odometer Reading End _____ Time _____ AM/PM	
14. Name of Facility		15. Type of Facility or Reason for Trip	
16. Waiting Time AM/PM to _____ AM/PM		17. Second Attendant's Name	
18. Multiple Riders this Trip Yes _____ No _____		19. Name of Primary Rider	
20. Wheelchair? Yes _____ No _____		Cot or Stretcher? Yes _____ No _____	
21. Signature of Person Verifying the Medicaid-Covered Service _____		Title _____	Date _____